Michigan Dept. of Treasury, Local Audit & Finance Division
496 (3-98), Formerly L-3147

AUDITING PROCEDURES REPORT

Issued under P.A. 2 of 1968, as amended. Filing is mandatory.

Local Government Type: ☐ City ☐ Township ☐ Village ☒ Other	Local Government Name: West Shore Medical Center	County Manistee
Audit Date June 30, 2004	Opinion Date September 16, 2004	Date Accountant Report Submitted To State: December 21, 2004

We have audited the financial statements of this local unit of government and rendered an opinion on financial statements prepared in accordance with the Statements of the Governmental Accounting Standards Board (GASB) and the *Uniform Reporting Format for Financial Statements for Counties and Local Units of Government in Michigan* by the Michigan Department of Treasury.

We affirm that:

1. We have complied with the *Bulletin for the Audits of Local Units of Government in Michigan* as revised.
2. We are certified public accountants registered to practice in Michigan.

We further affirm the following. "Yes" responses have been disclosed in the financial statements, including the notes, or in the report of comments and recommendations.

You must check the applicable box for each item below:

☐ yes ☒ no 1. Certain component units/funds/agencies of the local unit are excluded from the financial statements.

☐ yes ☒ no 2. There are accumulated deficits in one or more of this unit's unreserved fund balances/retained earnings (P.A. 275 of 1980).

☐ yes ☒ no 3. There are instances of non-compliance with the Uniform Accounting and Budgeting Act (P.A. 2 of 1968, as amended).

☐ yes ☒ no 4. The local unit has violated the conditions of either an order issued under the Municipal Finance Act or its requirements, or an order issued under the Emergency Municipal Loan Act.

☐ yes ☒ no 5. The local unit holds deposits/investments which do not comply with statutory requirements. (P.A. 20 of 1943, as amended [MCL 129.91] or P.A. 55 of 1982, as amended [MCL 38.1132])

☐ yes ☒ no 6. The local unit has been delinquent in distributing tax revenues that were collected for another taxing unit.

☐ yes ☒ no 7. The local unit has violated the Constitutional requirement (Article 9, Section 24) to fund current year earned pension benefits (normal costs) in the current year. If the plan is more than 100% funded and the overfunding credits are more than the normal cost requirement, no contributions are due (paid during the year).

☐ yes ☒ no 8. The local unit uses credit cards and has not adopted an applicable policy as required by P.A. 266 of 1995 (MCL 129.241).

☐ yes ☒ no 9. The local unit has not adopted an investment policy as required by P.A. 196 of 1997 (MCL 129.95).

We have enclosed the following:	**Enclosed**	**To Be Forwarded**	**Not Required**
The letter of comments and recommendations.	☒	☐	☐
Reports on individual federal assistance programs (program audits).	☐	☐	☒
Single Audit Reports (ASLGU).	☐	☐	☒

Certified Public Accountant (Firm Name): **PLANTE & MORAN, PLLC**			
Street Address 1111 Michigan Avenue	City East Lansing	State MI	ZIP 48823
Accountant Signature Plante & Moran, PLLC			

West Shore Medical Center

Financial Report

June 30, 2004

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West Shore Medical Center

Financial Report

June 30, 2004

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Independent Auditor's Report

To the Board of Trustees
West Shore Medical Center

We have audited the accompanying balance sheet of West Shore Medical Center as of June 30, 2004 and 2003, and the related statements of revenue, expenses, and changes in net assets and cash flows for the years then ended. These financial statements are the responsibility of the Center's management. Our responsibility is to express an opinion on these financial statements based on our audits.

We conducted our audits in accordance with auditing standards generally accepted in the United States of America. Those standards require that we plan and perform the audits to obtain reasonable assurance about whether the financial statements are free of material misstatement. An audit includes examining, on a test basis, evidence supporting the amounts and disclosures in the financial statements. An audit also includes assessing the accounting principles used and significant estimates made by management, as well as evaluating the overall financial statement presentation. We believe that our audits provide a reasonable basis for our opinion.

In our opinion, the financial statements referred to above present fairly, in all material respects, the financial position of West Shore Medical Center as of June 30, 2004 and 2003, and the results of its operations and its cash flows, for the years then ended in conformity with accounting principles generally accepted in the United States of America.

The Management's Discussion and Analysis is presented for purposes of additional analysis and is not a required part of the financial statements of West Shore Medical Center, but is supplemental information required by the Governmental Accounting Standards Board. We have applied certain limited procedures, which consisted principally of inquiries of management regarding the methods of measurement and presentation of the supplemental information. However, we did not audit the information and, accordingly, do not express an opinion thereon.

Plante & Moran, PLLC

September 16, 2004

This discussion and analysis of West Shore Medical Center's (the Medical Center) financial statements provides an overview of financial activities for the year ended June 30, 2004. Management is responsible for the completeness and fairness of the financial statements, the related footnote disclosures, and this discussion and analysis.

Using this Annual Report

The Medical Center's financial statements consist of three statements - a Balance Sheet; a Statement of Revenue, Expenses, and Changes in Net Assets; and a Statement of Cash Flows. These financial statements and related notes provide information about the activities of the Medical Center, including resources held by the Medical Center but restricted for specific purposes by contributors, grantors, or enabling legislation.

Financial Overview

The Medical Center's overall financial condition continued to improve during the year ended June 30, 2004 (fiscal 2004) as net assets increased $1.34 million from $26.14 million to $27.48 million (5.1 percent increase). The increase in net assets remained consistent with fiscal 2003, when net assets increased $1.02 million or 4.1 percent. Total cash and investments, including those limited as to use, decreased from $18.2 million to $15.9 million (12.6 percent decrease) as the Medical Center continued to make facility improvements and technological enhancements.

Investments in capital assets totaled $2.6 million and $3.9 million in fiscal years 2004 and 2003, respectively. No additional debt was required in 2004 or 2003 for the financing of these capital assets.

As mentioned, net assets increased by $1.34 million and $1.02 million in fiscal years 2004 and 2003, respectively, and were generated from the following sources (in thousands):

	Year Ended June 30	
	2004	2003
Income from operations	$ 1,315	$ 775
Nonoperating income (loss)	(36)	116
Contributions restricted for capital assets	59	130
Increase in Net Assets	**$ 1,338**	**$ 1,021**

Financial Overview (Continued)

Net assets by donor classification for the fiscal 2004 and 2003, were as follows (in thousands):

	Year Ended June 30	
	2004	2003
Invested in capital asset, net of related debt	$ 10,600	$ 10,414
Restricted for capital asset expenditures	165	357
Unrestricted	16,712	15,368
Total Net Assets	**$ 27,477**	**$ 26,139**

Balance Sheet and the Statement of Revenues, Expenses, and Changes in Net Assets

The Balance Sheet and the Statement of Revenues, Expenses, and Changes in Net Assets report information on the Medical Center as a whole and on its activities in a manner that helps present changes in its overall financial condition and operating performance.

These two statements taken together report the Medical Center's net assets and changes thereto from year-to-year, thus reflecting the financial health of the Medical Center. Many other non-financial factors should also be considered such as trends in patient days, outpatient visits, reimbursement levels, conditions of facilities, and strength of medical staff to assess the overall health of the Medical Center.

The statements include all assets and liabilities using the accrual basis of accounting. Revenue and expenses are recognized and accounted for regardless of when cash is received or paid.

Condensed Financial Information

The following is a comparative analysis of the major components of the Balance Sheet for fiscal 2004 and 2003 (in thousands):

	Year Ended June 30		Change	
	2004	2003	Amount	Percent %
Current assets	$ 17,232	$ 18,638	$ (1,406)	(7.5)
Non-current assets	4,376	3,282	1,094	33.3
Capital assets	21,940	22,139	(199)	(0.1)
Total assets	**$ 43,548**	**$ 44,059**	**$ (511)**	**(1.4)**
Current liabilities	$ 5,136	$ 6,580	$ (1,444)	(21.9)
Long-term liabilities	10,935	11,340	(405)	(3.6)
Total liabilities	**$ 16,071**	**$ 17,920**	**$ (1,849)**	**(10.3)**
Invested in capital assets, net of debt	$ 10,600	$ 10,414	$ 186	1.8
Restricted assets	165	357	(192)	(53.8)
Unrestricted	16,712	15,368	1,344	8.7
Total net assets	**$ 27,477**	**$ 26,139**	**$ 1,338**	**5.1**

Significant balance sheet changes include an increase in patient receivables and investment of cash and cash equivalents in long-term government agency securities. Liabilities decreased as a result of the second principal payment on revenue bonds and a decrease in Medicare and Medicaid cost reports settlements payable. Net assets increased due to positive operating results and contributions, offset by use of restricted net assets (held in trust) to complete the facility expansion program.

Operating Results for the Year

A comparative summary of operating results for the years ended June 30, 2004 and 2003, is as follows (in thousands):

	Year Ended June 30		Change	
	2004	2003	Amount	Percent %
Operating Revenue				
Net patient service revenue	$ 31,354	$ 28,961	$ 2,393	8.3
Other	649	673	(24)	(3.6)
Total operating revenue	32,003	29,634	2,369	8.0
Operating Expenses				
Salaries	12,427	12,194	233	1.9
Benefits	4,719	4,127	592	14.3
Supplies	3,711	4,049	(338)	(8.3)
Outside Services	4,809	4,211	598	14.2
Depreciation	2,592	2,285	307	13.4
Other	2,430	1,993	437	21.9
Total operating expenses	30,688	28,859	1,829	6.3
Income From Operations	1,315	775	540	(69.7)
Non Operating Income, Net	(36)	116	(152)	(131.0)
Excess of Revenue Over Expenses Before Restricted Contributions	1,279	891	388	43.5
Restricted Contributions	59	130	(71)	(54.6)
Increase in Net Assets	1,338	1,021	**$ 317**	**31.0**
Net Assets - Beginning of year	26,139	25,118		
Net Assets - End of year	**$ 27,477**	**$ 26,139**		

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Operating Results for the Year (Continued)

Operating Revenue

Operating revenue includes all transactions from healthcare and related service activity such as inpatient stays, outpatient visits and physician office rentals. In addition, certain state and private grants are operating in nature if they are not for capital purposes.

Operating revenue changes were a result of the following factors:

- Gross charges for patient services grew 10.2 percent from $46.8 million in fiscal 2003 to $51.6 million in fiscal 2004, due to general price increases averaging 5 percent, an increase in weighted outpatient activity of 4.4 percent and an increase in inpatient admissions of 7.0 percent (resulting in 8.9 percent more patient days of care).

- After accounting for adjustments and discounts under third-party payor programs, primarily Medicare, Medicaid, and Blue Cross Blue Shield of Michigan, and providing for uncollectible accounts (bad debts), the Medical Center realized an increase in net patient revenue of 8.3 percent, from $29.0 million in fiscal 2003 to $31.4 million in fiscal 2004.

- Deductions from revenue for third-party discounts and bad debts represented 38.2 and 39.2 percent of gross charges in fiscal years 2003 and 2004, respectively.

- Other operating revenue remained consistent at $649,000 in fiscal 2004 compared to $673,000 in fiscal 2003.

Gross patient charges and other income, as a percent of total for 2004 and 2003, were as follows:

	2004	%	2003	%
Inpatient	35		34	
Outpatient	64		65	
Other	1		1	
Total	**100**		**100**	

<u>Operating Results for the Year (Continued)</u>

Operating Expenses

Operating expenses are all costs necessary to provide healthcare services. Significant changes in operating expenses in fiscal 2004 were:

- Salaries increased $233,000 or 1.9 percent due to annual cost-of-living and market adjustments, offset by productivity improvements.
- Benefit costs increased $592,000 or 14.3 percent due primarily to increases in health insurance premiums.
- Supplies decreased $338,000 or 8.4 percent in 2004 due primarily to surgical supplies totaling $540,000 inventoried utilizing a newly installed inventory management system. Without this inventory change, supply costs would have increased to 4,250,000 or 5.0 percent.
- Outside services increased $598,000 or 14.2 percent due to more contracted labor for direct patient care.
- Depreciation increased $307,000 or 13.4 percent due to the completion of a $12 million expansion project completed in 2003 and salvage value write off on fixed assets whose estimated economical life was completed in 2004.

Operating expenses as a percent of total incurred in fiscal 2004 and 2003, were as follows:

	2004 %	2003 %
Salaries	40.5	42.2
Benefits	15.4	14.3
Supplies	12.1	14.0
Outside services	15.7	14.6
Depreciation	8.4	7.9
Other	7.9	7.0
Total	**100**	**100**

Operating Results for the Year (Continued)

Nonoperating Revenues, Net of Expenses

Nonoperating revenues are from other sources and for certain uses that are not primary to the Medical Center's operating activity, consisting primarily of investment earnings (including realized and unrealized gains and losses), offset by interest expense.

Net operating revenue, net of expenses decreased from $116,000 to $(36,000) in fiscal 2004, due primarily to realized and unrealized losses on certain investments.

Contributions Restricted for Capital Assets

Contributions restricted for capital assets relate primarily to gifts pledged or received in support of certain equipment needs.

Statement of Cash Flows

The primary purpose of the Statement of Cash Flows is to provide relevant information about the Medical Center's sources and uses of cash. The Statement of Cash Flows also helps assess:

- The Medical Center's ability to generate future positive cash flows.
- Its ability to meet obligations as they come due.
- Its ability to invest in capital assets for long-term growth and viability.

	2004	2003	Increase (Decrease)
Cash provided (used) (in thousands):			
Operating activities	$ 683	$ 3,489	$ (2,806)
Capita (net) and related financing activities	(3,121)	(4,275)	1,154
Noncapital financing activities	28	(4)	32
Investing activities	1,955	(13,437)	15,392
Net increase (decrease) in cash	(455)	(14,227)	**$ 13,772**
Cash - Beginning of the year	1,310	15,537	
Cash - End of year	**$ 855**	**$ 1,310**	

Statement of Cash Flows (Continued)

Cash provided by operating activities in 2004 decreased $2.8 million from the prior year due primarily to decreased collections from patients and third-party payors and to certain cost report settlement payments totaling $1.7 million. Also, payments to suppliers and employees increased $1.4 million.

Capital and related financing activities decreased from $4.3 million to $3.1 million in fiscal 2004 due primarily to completion of various facility improvement projects in fiscal 2003. Expenditures for property and equipment totaled $3.9 million in 2003 and $2.5 million in 2004.

Investing activities reflect the Medical Center's strategy to invest available operating funds in longer duration, higher yielding government-backed securities. The net increase in investments totaled $13.9 million in 2003 compared to a net decrease in investments totaling $1.6 million in 2004.

Capital Asset and Debt Administration

Capital Assets

At June 30, 2004, the Medical Center's capital assets totaled $21.9 million, net of accumulated depreciation of $18.6 million. The Medical Center's capital position represents an average age of 7.2 years in 2004, compared with 7.0 years in 2003.

Debt

In April 2001, the Medical Center incurred long-term debt totaling $12.1 million, to support a facility expansion and modernization program. Debt outstanding at June 2004 totaled $11.3 million, of which $405,000 was short-term in nature, consisted of adjustable rate (1.18 percent at June 30, 2004), tax-exempt revenue bonds, and secured by an irrevocable direct-pay letter of credit.

In November 2002, the Medical Center entered into an interest rate swap agreement to reduce interest rate risk on a beginning notational amount of $6.0 million, decreasing to $5.0 million by the end of the five-year agreement.

Refer to Notes 7 and 8 to the financial statements for additional information relating to debt and the interest rate swap agreement.

Economic Factors That Will Affect the Future

Although the Medical Center generated revenues in excess of expenses from operations, like other hospitals it continues to be challenged in an environment where reimbursement gains from third-party payors are not keeping pace with primary cost drivers, such as wages, health insurance, and contract labor. In addition, management is growing concerned with recent pressures on professional liability insurance and energy costs.

In recent years, growth in outpatient activity has operationally not kept pace to adequately offset decreases in inpatient admissions. As reflected in the Medical Center's 2004 financial results, however, operating margin increased to 4.1 from 2.6 percent. This improved performance was due primarily to an increase in inpatient activity and corresponding productivity gains. Inpatient admissions increased 7.0 percent in 2004, after decreasing in the prior two years. Management believes the Medical Center's future success will be driven by its ability to sustain growth in inpatient services and to access adequate capital to fund facility expansion and technological enhancements.

The Medical Center is continuing its aggressive physician recruitment initiative. This initiative will require significant investment in physician practice start-up activities and office facilities. By helping to create a larger network of physicians, however, the Medical Center will enhance local access to quality care and be better positioned to meet the growing healthcare needs of communities served.

Contacting the Medical Center's Management

This financial report is intended to provide interested parties with a general overview of the Medical Center’s financial position and performance. The Medical Center has achieved a strong financial position during difficult economic times for the health services industry in the state of Michigan. Management believes the Medical Center is well positioned to provide and enhance healthcare services for communities served for years to come.

If you have any questions about this report or need additional information, please contact the Vice President, Finance.

Donn Lemmer
Vice President, Finance
231.398.1188

West Shore Medical Center

Balance Sheet

	June 30 2004	June 30 2003
Assets		
Current Assets		
Cash and cash equivalents (Note 2)	$ 393,996	$ 770,417
Investments and assets limited as to use (Note 5)	11,359,202	14,362,354
Accounts receivable (Note 3)	3,488,051	2,090,734
Inventories	1,062,228	700,628
Prepaid expenses	528,221	513,749
Cost report settlements receivable (Note 4)	400,000	199,970
Total current assets	17,231,698	18,637,852
Investments and Assets Limited as to Use (Notes 2 and 5)	4,177,561	3,033,495
Capital Assets, Net (Note 6)	21,940,386	22,139,452
Other Assets	198,800	248,361
Total assets	**$ 43,548,445**	**$ 44,059,160**
Liabilities and Net Assets		
Current Liabilities		
Current portion of long-term debt (Note 7)	$ 405,000	$ 385,000
Accounts payable	1,680,760	1,958,029
Accrued liabilities (Note 9)	2,804,468	2,848,957
Cost report settlements payable (Note 4)	246,002	1,387,997
Total current liabilities	5,136,230	6,579,983
Long-Term Debt (Note 7)	10,935,000	11,340,000
Total liabilities	16,071,230	17,919,983
Net Assets		
Invested in capital assets net of related debt	10,600,386	10,414,452
Restricted for capital asset expenditures	165,205	356,743
Unrestricted	16,711,624	15,367,982
Total net assets	27,477,215	26,139,177
Total liabilities and net assets	**$ 43,548,445**	**$ 44,059,160**

West Shore Medical Center

Statement of Revenue, Expenses, and Changes in Net Assets

	Year Ended June 30	
	2004	2003
Operating Revenue		
Net patient service revenue (Note 12)	$ 31,354,299	$ 28,961,471
Other operating revenue	649,083	672,971
Total operating revenue	32,003,382	29,634,442
Operating Expenses		
Salaries	12,427,235	12,193,810
Benefits	4,719,187	4,126,747
Supplies	3,710,668	4,049,061
Professional fees and outside services	4,809,113	4,211,468
Depreciation	2,592,021	2,285,151
Other	2,430,276	1,992,862
Total operating expenses	30,688,500	28,859,099
Income From Operations	1,314,882	775,343
Nonoperating Income and Expenses, Net (Note 13)	(36,285)	115,356
Excess of Revenue Over Expenses Before Contributions Restricted for Capital Assets	1,278,597	890,699
Contributions Restricted for Capital Assets	59,441	129,990
Increase in Net Assets	1,338,038	1,020,689
Net Assets - Beginning of Year	26,139,177	25,118,488
Net Assets - End of Year	**$ 27,477,215**	**$ 26,139,177**

West Shore Medical Center

Statement of Cash Flows

	Year Ended June 30	
	2004	2003
Cash Flows From Operating Activities		
Cash received from patients and third-party payors	$ 28,614,957	$ 30,281,917
Other receipts and payments	692,341	680,151
Cash paid to suppliers and employees	(28,624,748)	(27,472,922)
Net cash provided by operating activities	682,550	3,489,146
Cash Flows From Capital and Related Financing Activities		
Purchase of property and equipment	(2,575,453)	(3,883,416)
Restricted contributions received for capital assets	59,441	129,990
Cash received from sale of property and equipment	19,240	79,105
Principal paid on long-term debt	(385,000)	(370,000)
Interest paid on long-term debt	(239,695)	(231,345)
Net cash used in capital and related financing activities	(3,121,467)	(4,275,666)
Cash Flows From Noncapital Financing Activities		
Noncapital contributions	50,100	5,957
Net payments made on scholarship loans	(21,759)	(9,854)
Net cash provided by (used in) noncapital financing activities	28,341	(3,897)
Cash Flows From Investing Activities		
Purchase of investments	(6,408,729)	(16,449,336)
Interest received on investments	368,931	442,423
Proceeds from sale of investments	7,995,128	2,570,017
Net cash provided by (used in) investing activities	1,955,330	(13,436,896)
Net Decrease in Cash and Cash Equivalents	(455,246)	(14,227,313)
Cash and Cash Equivalents - Beginning of year	1,309,794	15,537,107
Cash and Cash Equivalents - End of year	**$ 854,548**	**$ 1,309,794**

	Year Ended June 30	
	2004	2003
Balance Sheet Classification of Cash		
General fund - Cash and cash equivalents	$ 393,996	$ 770,417
Restricted funds - Cash and cash equivalents	127,448	203,606
Assets limited as to use - Cash and cash equivalents	333,104	335,771
Total	**$ 854,548**	**$ 1,309,794**

	Year Ended June 30	
	2004	2003
Reconciliation of Revenue and Gains in Excess of Expenses to Net Cash Provided by Operating Activities		
Income from operations	$ 1,314,882	$ 775,343
Adjustments to reconcile income from operations to net cash provided by operating activities:		
Depreciation	2,592,021	2,285,151
Amortization	49,561	16,459
Loss on sale of assets	43,258	7,180
Provision for bad debts	1,116,621	1,043,938
(Increase) decrease in assets:		
Accounts receivable	(2,513,938)	(516,519)
Inventories	(361,600)	(103,111)
Prepaid expenses	(14,472)	(172,458)
Cost report settlements receivable	(200,030)	300,030
Increase (decrease) in liabilities:		
Accounts payable	(157,269)	(345,923)
Accrued liabilities	(44,489)	(293,941)
Cost report settlements payable	(1,141,995)	492,997
Net cash provided by operating activities	**$ 682,550**	**$ 3,489,146**

There were no noncash capital and related financing activities, noncapital financing activities and investing activities during 2004 and 2003.

Note 1 - Nature of Business and Significant Accounting Policies

Reporting Entity - West Shore Medical Center (the Center) operates as a short-term, acute care facility offering inpatient and outpatient health care services primarily to citizens of northwest Michigan. A significant portion of the Center's net patient service revenue is receivable under contractual arrangements with Medicare, Medicaid, and Blue Cross Blue Shield of Michigan programs. The Center is organized under Public Act 230 of the Public Acts of 1987.

The Center is a component unit of Manistee County and is governed by its own Board of Trustees, who are appointed by the County of Manistee, and functions as a separate and distinct corporate body from the County. The Center is not empowered to create, in any fashion, debt or liabilities on behalf of the County or to pledge the full faith and credit of the County.

The West Shore Healthcare Foundation (the Foundation), which is controlled by West Shore Medical Center, was established to solicit contributions from the general public solely for the funding of capital asset acquisitions by the Center. Funds are distributed to the Center as determined by the Foundation's Board of Trustees.

Use of Estimates - The preparation of financial statements in conformity with accounting principles generally accepted in the United States of America requires management to make estimates and assumptions that affect certain reported amounts and disclosures in the financial statements. Actual results could differ from those estimates.

Basis of Presentation - The financial statements have been prepared in accordance with accounting principles generally accepted in the United States of America as prescribed by the Governmental Accounting Standards Board (GASB) in Statement No. 34, *Basic Financial Statements - and Management's Discussion and Analysis - for State and Local Governments,* issued June 1999. The Center follows the "business-type" activities reporting requirements of GASB Statement No. 34 that provides a comprehensive look at the Center's financial activities. No component units are required to be reported in the Center's financial statements.

Enterprise Fund Accounting - The Center uses enterprise fund accounting. Revenues and expenses are recognized on the accrual basis using the economic resources measurement focus. Based on Governmental Accounting Standards (GASB) Statement No. 20, *Accounting and Financial Reporting for Proprietary Funds and Other Governmental Entities That Use Proprietary Fund Accounting*, as amended, the Center has elected to apply the provisions of all relevant pronouncements of the Financial Accounting Standards Board (FASB), including those issued after November 30, 1989, that do not conflict with or contradict GASB pronouncements.

Note 1 - Nature of Business and Significant Accounting Policies (Continued)

Cash and Cash Equivalents - The Center considers all liquid investments purchased with an original maturity date of three months or less to be cash and cash equivalents.

Investments - Investments are stated at fair market value. Investment income or loss, including realized and unrealized gains and losses on investments and interest, and dividends, is included in nonoperating income unless the income or loss is restricted by donor or law.

Inventories - Inventories are stated at the lower of cost, determined by the first-in, first-out method or market. Inventoriable items include dietary, pharmacy, laboratory, surgical, and patient billable supplies.

Capital Assets - Capital asset acquisitions consisting of property and equipment are recorded at cost. Donations of capital assets are stated at fair market value at date of donation. Depreciation is computed principally on the straight-line basis over the estimated useful lives of the assets. Costs of maintenance and repairs are charged to expense when incurred.

Contributions - From time to time, the Center receives contributions from individuals and private organizations. Revenues from these sources (including contributions of capital assets) are recognized when all eligibility requirements, including time requirements, are met. Contributions may be restricted for either specific operating purposes or for capital purposes. Contributions restricted for operating purposes are reported as nonoperating income. Contributions restricted for capital acquisitions are reported after nonoperating income.

Net Assets - Net assets of the Center are classified in three components. *Net assets invested in capital assets net of related debt* consist of capital assets net of accumulated depreciation and reduced by outstanding borrowings used to finance the purchase or construction of those assets. *Restricted net assets* are noncapital net assets that must be used for a particular purpose, as specified by creditors, grantors, or contributors external to the Center, including amounts deposited with trustees as required by revenue bond indentures, discussed in Note 5. *Unrestricted net assets* are the remaining net assets that do not meet the definition of *net assets invested in capital assets net of related debt* or *restricted net assets.*

Note 1 - Nature of Business and Significant Accounting Policies (Continued)

Operating Revenue and Expenses - The Center's statement of revenue, expenses, and changes in net assets distinguishes between operating and nonoperating revenue and expenses. Operating revenue results from transactions associated with providing health care services - the Center's principal activity. Other revenue including investment income, contributions received for purposes other than capital asset acquisition and interest expense are reported as nonoperating income. Operating expenses are all expenses incurred to provide health care services, other than financing costs.

Net Patient Service Revenue - Net patient service revenue is reported at the estimated net realizable amounts from patients, third-party payors, and others for services rendered, including estimated retroactive adjustments under reimbursement agreements with third-party payors. Retroactive adjustments are accrued on an estimated basis in the period the related services are rendered and adjusted in future periods as final settlements are determined (Note 4).

Laws and regulations governing the Medicare and Medicaid programs are extremely complex and subject to interpretation and management believes it is in compliance with these laws and regulations. Compliance with such laws and regulations can be subject to future government review and interpretation as well as significant regulatory action including fines, penalties, and exclusion from the Medicare and Medicaid programs.

Pension Plans - The Center has four noncontributory, trustee, defined contribution pension plans covering substantially all employees. The Center's policy is to fund pension cost as participants qualify for contributions (Note 10). The Center also offers a deferred compensation plan under Section 457 of the Internal Revenue Code to employees who wish to participate.

Professional Liability Insurance - The Center accrues the estimated ultimate expense, including litigation and settlement expense, for the reported incidents of alleged medical malpractice occurring during the year, as well as the estimated cost of those claims that have not been reported to the insurance carrier at year end (Note 11).

Note 1 - Nature of Business and Significant Accounting Policies (Continued)

Charity Care - The Center provides care to patients who meet certain criteria under its charity care policy without charge or at amounts less than its established rates. Because the Center does not pursue collection of amounts determined to qualify as charity care, they are not reported as operating revenue. Charity care for the years ending June 30, 2004 and 2003, totaled approximately $63,000 and $33,000, respectively.

Tax Status - The Center is a municipal health facilities organization under Public Act 230 of State of Michigan law and is tax exempt under the Internal Revenue Code. Accordingly, no tax provision is reflected in the financial statements.

Note 2 - Deposits and Investments

The Center's deposits and investments are included in the balance sheet under the following classifications:

2004	Cash and Cash Equivalents	Investments and Assets Limited as to Use (Note 5)	Total
Deposits	$ 393,996	$ 460,552	$ 854,548
Investments	-	14,972,461	14,972,461
Totals	$ 393,996	$ 15,433,013	$ 15,827,009
2003			
Deposits	$ 770,417	$ 539,377	$ 1,309,794
Investments	-	16,659,101	16,659,101
Totals	$ 770,417	$ 17,198,478	$ 17,968,895

Note 2 - Deposits and Investments (Continued)

Deposits - The above deposits were reflected in the accounts of the bank (without recognition of checks written, but not yet cleared, or of deposits-in-transit) at $962,970 for 2004 and $1,750,975 for 2003. Of those amounts, $100,000 for 2004 and 2003 was covered by federal depository insurance, and $862,970 and $1,650,975 was uninsured and uncollateralized for June 30, 2004 and 2003, respectively. The Center believes that, due to the dollar amounts of cash deposits and the limits of FDIC insurance, it is impractical to insure all bank deposits. As a result, the Center evaluates each financial institution it deposits Center funds with and assesses the level of risk of each institution; only those institutions with an acceptable estimated risk level are used as depositories.

Investments - The Center is authorized under the laws of the State of Michigan to invest surplus monies (of non-pension funds) in U.S. bonds and notes, certain commercial paper, U.S. government repurchase agreements, bankers acceptances and mutual funds, and investment pools that are composed of authorized investment vehicles.

The Center's investments are categorized to give an indication of the level of risk assumed by the entity at June 30, 2004 and 2003. The Center's investments in U.S. government securities are categorized as Risk Category 1. Risk Category 1 includes investments which meet any one of the following criterion:

a. Insured
b. Registered
c. Held by the Center or its agent

Risk categories 2 and 3 include investments that are neither insured nor registered. Category 2 includes investments that are held by the counterparty's trust department (or agent) in the Center's name. Category 3 includes investments held by:

a. The counterparty, or
b. The counterparty's trust department (or agent) but not in the Center's name.

Note 2 - Deposits and Investments (Continued)

The details of investments are as follows:

	Category			
2004	1	2	3	Market Value
Government securities	$ 6,280,246	$ -	$ -	$ 6,280,246
Mutual funds				8,692,215
Total investments				$ 14,972,461
2003				
Government securities	$ 6,190,833	$ -	$ -	$ 6,190,833
Mutual funds				10,468,268
Total investments				$ 16,659,101

The mutual funds are not categorized because they are not evidenced by securities that exist in physical or book entry form. The funds are regulated by the Michigan Banking Act and/or the Securities and Exchange Commission; the fair value of the position in the funds is the same as the value of the pool shares. Management believes that investments in the funds comply with investment authority noted above.

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Note 3 - Accounts Receivable

The details of accounts receivable are presented below:

	2004	2003
Patient accounts receivable	$ 7,158,506	$ 5,355,827
Less:		
Allowance for uncollectible accounts	(543,888)	(570,651)
Allowance for contractual adjustments	(3,384,785)	(2,979,477)
Total patient accounts receivable	3,229,833	1,805,699
Other	258,218	285,035
Total accounts receivable	$ 3,488,051	$ 2,090,734

The Center grants credit without collateral to its patients, most of whom are local residents and are insured under third-party payor agreements. The composition of accounts receivable from patients and third-party payors is as follows:

	2004	2003
Medicare	29 %	31 %
Medicaid	14	13
Blue Cross Blue Shield of Michigan	20	17
Commercial insurance	21	22
Patients	16	17
Total	100 %	100 %

Note 4 - Cost Report Settlements

The Center has agreements with these payors that provide for reimbursement to the Center at amounts different from its established rates. A summary of the basis of reimbursement is as follows:

- **Medicare** - Inpatient, acute-care services rendered to Medicare program beneficiaries are paid at prospectively determined rates per discharge. These rates vary according to a patient classification system that is based on clinical, diagnostic, and other factors. Most outpatient services, including ambulatory surgery, outpatient radiology, and other diagnostic related services are reimbursed on a prospectively determined ambulatory payment classification system. Physical therapy and outpatient laboratory services are reimbursed on a fee-for-service methodology.

- **Medicaid** - Inpatient, acute-care services rendered to Medicaid program beneficiaries are also paid at prospectively determined rates per discharge. Inpatient capital costs relating to Medicaid patients are paid on a cost-reimbursement method. Outpatient services are reimbursed on an established fee-for-service methodology.

- **Blue Cross Blue Shield of Michigan** - All services rendered to Blue Cross Blue Shield of Michigan subscribers are reimbursed based on a percentage of Center charges.

Cost report settlements receivable and payable result from the adjustment of interim payments to final reimbursement under these programs, and is subject to audit by each responsible intermediary. These audits may result in changes to these estimated cost report settlement balances and will be adjusted in future periods as final settlements are determined. Final cost report settlements increased net patient service revenue by approximately $750,000 and $320,000 for the years ended June 30, 2004 and 2003, respectively, reflecting settlements received for prior years in excess of previously estimated amounts.

Note 5 - Investments and Assets Limited as to Use

The details of investments and assets limited as to use for the years ended June 30, 2004 and 2003 are detailed below. The composition of investments is detailed in Note 2.

	2004	2003
Assets Limited as to Use:		
Designated by Board for:		
Payment of potential professional liability claims		
Municipal investment fund - Cash and cash equivalents	$ 169,430	$ 169,416
Endowments - Cash and cash equivalents	58,918	67,951
Scholarship loans	55,993	34,234
Other - Cash and cash equivalents	104,756	98,404
Restricted by Foundation for:		
Building improvements - Cash and cash equivalents	127,448	203,606
Building improvements - Contributions receivable	37,557	99,958
Other	200	53,179
Total restricted by Foundation	165,205	356,743
Total assets limited as to use	554,302	726,748
Unrestricted investments:		
Investments	14,972,461	16,659,101
Other	10,000	10,000
Total investments and assets limited as to use	15,536,763	17,395,849
Less current portion for short-term investments	11,359,202	14,362,354
Total long-term investments and assets limited as to use	$ 4,177,561	$ 3,033,495

Note 6 - Capital Assets

Capital asset activity for the years ended June 30, 2004 and 2003, was as follows:

	July 1, 2003	Additions	Retirements	Transfers to (From)	June 30, 2004	Depreciable Life - Years
Land	$ 91,192	$ -	$ -	$ -	$ 91,192	-
Land improvements	755,464	-	-	33,155	788,619	10-20
Building and improvements	18,449,191	172,397	-	1,512,539	20,134,127	10-40
Equipment and furnishings	18,147,072	1,073,021	128,413	235,790	19,327,470	3-20
Construction-in-progress	803,307	1,210,035	-	(1,781,484)	231,858	
Total	38,246,226	2,455,453	128,413	-	40,573,266	
Less accumulated depreciation:						
Land improvements	432,640	41,068	-	-	473,708	
Building and improvements	4,183,174	1,028,742	-	-	5,211,916	
Equipment and furnishings	11,490,960	1,522,211	65,915	-	12,947,256	
Total	16,106,774	2,592,021	65,915	-	18,632,880	
Net carrying amount	$ 22,139,452	$ (136,568)	$ 62,498	$ -	$ 21,940,386	

	July 1, 2002	Additions	Retirements	Transfers to (From)	June 30, 2003	Depreciable Life - Years
Land	$ 91,192	$ -	$ -	$ -	$ 91,192	-
Land improvements	675,221	26,320	-	53,923	755,464	10-20
Building and improvements	14,602,345	33,742	-	3,813,104	18,449,191	10-40
Equipment and furnishings	16,817,547	1,303,481	177,575	203,619	18,147,072	3-20
Construction-in-progress	2,234,490	2,639,463	-	(4,070,646)	803,307	
Total	34,420,795	4,003,006	177,575	-	38,246,226	
Less accumulated depreciation:						
Land improvements	399,070	33,570	-	-	432,640	
Building and improvements	3,265,496	917,678	-	-	4,183,174	
Equipment and furnishings	10,248,347	1,333,903	91,290	-	11,490,960	
Total	13,912,913	2,285,151	91,290	-	16,106,774	
Net carrying amount	$ 20,507,882	$ 1,717,855	$ 86,285	$ -	$ 22,139,452	

Note 7 - Long-Term Debt

Long-term debt for the years ended June 30, 2004 and 2003, was as follows:

	July 1, 2003	Current Year Additions	Current Year Reductions	June 30, 2004	Current Portion
Bonds payable - 2001 Series	$ 11,725,000	$ -	$ 385,000	$ 11,340,000	$ 405,000

	July 1, 2002	Current Year Additions	Current Year Reductions	June 30, 2003	Current Portion
Bonds payable - 2001 Series	$ 12,095,000	$ -	$ 370,000	$ 11,725,000	$ 385,000

Long-term debt consists of Adjustable Rate Demand Bonds, Series 2001 issued by the Center. These bonds mature on April 1, 2022, and have a variable interest rate established on a weekly basis. The effective interest rate was 1.18 percent and 1.08 percent at June 30, 2004 and 2003, respectively. The bonds require annual payments ranging from $405,000 to $920,000 through April 1, 2022.

The bonds are secured by an irrevocable direct-pay letter of credit which expires in October 2007. The bonds are subject to mandatory redemption upon the expiration or termination of the letter of credit unless the existing letter of credit has been extended or an alternate letter of credit has been issued.

The variable rate series 2001 bonds described above are remarketed on a weekly basis. Should the remarketing agent be unable to remarket the bonds and notes based on its best efforts, the bonds and notes would be "put" back to the Trustee, who would draw down on the letter of credit to pay down the Series 2001 Bonds.

In conjunction with the issuance of the irrevocable direct-pay letter of credit and related agreements, the Hospital has agreed to certain quarterly and annual reporting requirements, certain financial covenants, and various other operational covenants.

Note 7 - Long-Term Debt (Continued)

A schedule of the principal and estimated interest payments on long-term debt at June 30, 2004, is as follows:

	Bonds Payable	Estimated Interest at Effective Rate of 1.18 Percent at June 30, 2004
2005	$ 405,000	$ 132,617
2006	425,000	127,779
2007	445,000	122,705
2008	470,000	117,381
2009	490,000	111,776
2010-2014	2,845,000	448,120
2015-2019	3,625,000	255,839
2020-2022	2,635,000	39,869
Total payments	$ 11,340,000	$ 1,356,086

Note 8 - Interest Rate Swap Agreement

During the year ended June 30, 2003, the Center entered into an interest rate swap of its Adjustable Rate Demand Health Facilities Revenue Bonds in notation amounts as detailed in the table below to reduce the impact of changes in the interest rate on its variable rate long-term debt. The swap agreement matures in November 2007. The effect of the swap was to effectively change the Center's variable interest rate on bonds to a synthetic fixed rate of 2.935 percent. At June 30, 2004, the swap had a positive fair value of approximately $60,000. Since the fair value of the swap was positive, the Center is exposed to credit risk in the amount of the interest rate swap's fair value. Because interest rates had declined since the execution of the swap through June 30, 2003, the swap had a negative fair value of approximately $70,000 at June 30, 2003, thus the Center was not exposed to any credit risk. The swap's counterparty is rated AA3 by Moody's, A+ by Standard and Poor's and AA- by Fitch. The Center or counterparty may terminate the interest rate swap agreement if either party fails to perform under the terms of a standard ISDA Master Agreement as amended. If terminated, the Center has the option of entering into a new interest rate swap agreement with another counterparty or convert variable rate bonds into a fixed rate bond. However, the Center does not anticipate nonperformance by the counterparties.

The notational amounts for each year, which the fixed rate will apply under the interest rate swap agreement, are as follows:

	Notational Amounts
Effective Date	$ 6,000,000
April 1, 2004	5,622,500
April 1, 2005	5,420,000
April 1, 2006	5,207,000
April 1, 2007	4,985,000

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Note 9 - Accrued Liabilities

The details of accrued liabilities are as follows:

	2004	2003
Payroll and related amounts	$ 776,512	$ 594,814
Pension (Note 10)	440,059	363,937
Compensated absences	1,265,451	1,295,726
Professional liability claims (Note 11)	302,898	286,906
Other	19,548	307,574
Total accrued liabilities	$ 2,804,468	$ 2,848,957

Compensated absences represent the estimated liability to be paid to employees under the Center's sick and vacation policy. Under the Center's policy, employees earn sick and vacation time based on length of service with the Center.

Note 10 - Pension

The Center provides benefits through four participant-directed defined contribution plans to substantially all employees who accumulate at least 1,000 hours of service per year. In a defined contribution plan, benefits depend solely on amounts contributed to the Plan plus investment earnings. Generally, employees are eligible to participate after one year of service and the attainment of age 21. The Center's contributions for each employee plus net investment income and interest allocated to each employee's account are fully vested in periods ranging from 5 years to 10 years of continuous service. Center contributions for, and interest forfeited by, employees who leave employment prior to being fully vested are used to reduce the Center's current-period contribution requirement. Pension expense, net of forfeitures, to the Plans for the years ended June 30, 2004 and 2003, totaled approximately $726,000 and $640,000, respectively.

Note 11 - Risk Management

The Center is exposed to various risks of loss related to property loss, torts, professional liability, errors and omissions, employee injuries, as well as medical benefits provided to employees. The Hospital has purchased commercial insurance for the various risks described above.

The Center is insured against potential professional and general liability claims under a claims-made policy, whereby only the claims reported to the insurance carrier during the policy period are covered regardless of when the incident giving rise to the claim occurred. Under the terms of the policy, the Center must pay a deductible towards the costs of litigation or settling any asserted claims. In addition, the Center bears the risk of the ultimate costs of any individual claim exceeding the policy limits for claims asserted in the policy year. At June 30, 2004 and 2003, the Center has made a provision for the estimated loss in connection with those professional liability claims for incidents occurring during the year for which an amount can be reasonably estimated, including a provision for claims incurred but not reported at year end.

Should the claims-made policy not be renewed or replaced with equivalent insurance, claims based on occurrences during the claims-made term, but reported subsequently, will be uninsured.

Note 12 - Net Patient Service Revenue

The details of net patient service revenue are as follows:

	2004	2003
Patient revenue:		
Inpatient	$ 18,200,800	$ 16,141,159
Outpatient	33,390,641	30,688,489
Total patient revenue	51,591,441	46,829,648
Revenue deductions:		
Provision for third-party payors	19,120,521	16,824,239
Provision for uncollectible accounts	1,116,621	1,043,938
Total revenue deductions	20,237,142	17,868,177
Net patient service revenue	$ 31,354,299	$ 28,961,471

Note 13 - Nonoperating Income and Expenses

The details of nonoperating income and expenses are as follows:

	2004	2003
Interest income	$ 368,644	$ 441,996
Net unrealized and realized losses on investments	(215,621)	(101,679)
Interest expense	(239,695)	(231,345)
Restricted contributions	50,100	5,957
Restricted investment income	287	427
Total	$ (36,285)	$ 115,356

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September 16, 2004

To the Board of Trustees
West Shore Medical Center

The healthcare industry continues in a period of rapid change, in terms of medical advances, capital requirements and changes in providing cost effective, high quality healthcare services. Our knowledge of the healthcare industry is continually expanding to reflect this changing environment. This knowledge provides the Center with both the vision and tools to be successful.

Our goal is to provide resources, recommendations, and knowledge to be successful in today's healthcare environment. Through our recent audit and our participation in various healthcare provider associations we are providing the following reports to assist you in deepening your knowledge base of items that may affect the Center in the near future:

I. Observations, Comments, and Recommendations
II. Plante & Moran Regulatory Heartbeat
III. Required Communication to Board of Trustees

As required by auditing standards generally accepted in the United States of America, the independent auditor is required to make several communications to the "audit committee" or a governing body having oversight responsibility for the audit. The purpose of this report letter is to provide you with additional information regarding the scope and results of our audit that may assist you with your oversight responsibilities of the financial reporting process for which management is responsible.

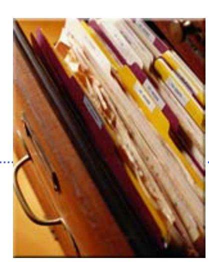
Thank you for the opportunity to be of service to the Center. Should you wish to discuss any of the items included in this report, we would be happy to do so.

Sincerely,

PLANTE & MORAN, PLLC

Kevin E. Krause, CPA
Partner

Observations, Comments, and Recommendations

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To the Board of Trustees
West Shore Medical Center

In planning and performing our audit of the financial statements of West Shore Medical Center for the year ended June 30, 2004, we considered the Center's internal control structure in order to determine our auditing procedures for the purpose of expressing our opinion on the financial statements. The consideration we gave to the internal control structure was not sufficient for us to provide any form of assurance on it. In reviewing the Center's processes and systems, we made a few observations that we feel should be communicated to you. We have also summarized additional areas for Board consideration.

All items are presented for your consideration on attachments as outlined below:

Title	Exhibit
Accounts Receivable	A
Fixed Assets Maintenance	B
HIPAA/Corporate Compliance	C
Internal Controls	D
West Shore Foundation	E

Thank you for the opportunity to be of service to the Center. Should you wish to discuss any of the items included in this report, we would be happy to do so.

Plante & Moran, PLLC

September 16, 2004

Exhibit A
Accounts Receivable

We noted the following items that we feel should be brought to your attention as it relates to patient accounts receivable:

- The average collection period for outstanding accounts receivable increased from 39 days in 2003 to 47 days in 2004. However, this still compares very favorably to the Center's peers in the state. Subsequent to year-end, outstanding accounts receivable decreased to approximately 35 days due to an increased focus on the billing of private pay and coinsurance amounts.

- The accounts receivable credit balance increased from approximately $330,000 in 2003 to $424,000 in 2004. Oftentimes, these balances result from payors and patients overpaying the Center for coinsurance or deductible portions of the bill, or from not properly posting cash receipts against proper patient accounts receivable balances. We understand the Center is working to resolve these balances and has contracted with outside vendors to assist in cleaning up these amounts. We recommend the Center continue its efforts in this area, particularly in the area of amounts owed back to Blue Cross and various commercial vendors.

- Total private pay accounts receivable balances have increased quite significantly over the past couple of years, totaling approximately $1.2 million in 2004 compared to a balance of approximately $600,000 in 2002. In addition, the allowance for uncollectible accounts has decreased somewhat over the past two years. At June 30, 2004, the allowance totaled 46 percent of self-pay accounts receivable balances, as compared to 62 percent in 2003. With the continued increasing of deductibles and co-insurance amounts being passed onto employees by employers, we highly recommend the Center closely monitor self-pay balances and more importantly, emphasis should be when appropriate, in collecting deductibles and co-insurance at time of service.

Exhibit B
Fixed Assets Maintenance

Currently, fixed asset records are being maintained on a computerized spreadsheet. Maintaining detailed fixed asset schedules on computerized spreadsheets has become more time consuming and the likelihood of errors increases with the significant amount of input and formula creation that is necessary to appropriately maintain the assets owned by the Center. In fact, during this year's audit, we noted many cases where rows were entered into the Excel spreadsheet, however, related formulas required for totaling were not updated to reflect the additional rows and certain assets that were properly recorded in the general ledger were not added to the Excel spreadsheet.

With the significant decreases in prices of various accounting software, many organizations of similar size maintain their fixed asset records using fixed asset accounting software or they have considered outsourcing this function to an outside provider. We recommend the Center consider purchasing fixed asset software to maintain its detailed listing or consider outsourcing the accounting for fixed assets to an outside provider.

Exhibit C
HIPAA/Corporate Compliance

We have identified the following areas that the Center should make a priority in the future:

- **Information Technology**

  In the upcoming year, the Center is considering upgrading their current or purchasing a new information technology system. While the Center will need to assess how the system will integrate multiple IT functions and system support, the Center should also assess the disaster recovery plan already in place and how it will integrate into the new system.

- **Chargemaster Review**

  The Center has not conducted a detailed chargemaster review performed by a third-party for a number of years, except for an ongoing APC review started in 2003. Due to the large number of changes in charge codes, due to changes resulting from APC's and DRG's, it is important that the Center's chargemaster be maintained with current allowable codes to avoid potential corporate compliance deficiencies. An external review of the Center's chargemaster would facilitate the effort to ensure current charge codes are in effect. We recommend the Center contract for an external review of its chargemaster.

Exhibit D
Internal Controls

With the continued move to electronic banking, it has become more important than ever to include written internal controls and policies related to wire transfers. Currently, there is no written policy in place associated with wire transfers. However, the Center currently has adequate procedures for wire transfers that were tested during the audit. We recommend a formal policy be adopted which clearly documents the controls and procedures required when wire transfers are initiated.

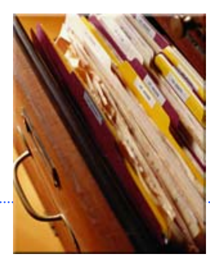
It is strongly believed that all organizations (small and large) have some level of risk in the internal controls area and even having the "best practices" in place will not necessarily prevent all fraud risk. Through many recent conversations with our clients regarding their susceptibility to fraud, it was noted the most important element necessary to reduce the risk of fraud is to have a sound organizational structure which includes sound accounting and internal control policies and procedures (in the eyes of their employees).

Exhibit E
West Shore Foundation

As a part of the preparation of the IRS 990 filing for the West Shore HealthCare Foundation, it was noted that the Bylaws of the Foundation require an annual audit of the Foundation by an independent certified public accountant. It is our understanding that no audits of the Foundation have been performed since the inception of the Foundation.

We recommend that the Board of Directors of the Foundation amend the Bylaws of the Foundation to explicitly state 'an annual audit is at the discretion of the Board of Directors' if they do not believe an annual audit is required.

Regulatory Heartbeat



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Plante & Moran Regulatory Heartbeat

Reimbursement Update

Medicare Reimbursement - Proposed Physician Ruling For Calendar Year 2005

- Payment increase of 1.5 percent
- CMS projects total 2005 spending for the approximately 850,000 healthcare professionals will increase 4 percent to $55 Billion.
- Other proposed changes include:
  - 5 percent incentive payments to physicians practicing in "physician scarcity areas" and 10 percent incentive for those practicing in "health professional shortage areas"
  - Initial physical for all new beneficiaries
  - New coverage of cardiovascular screening blood tests
  - Diabetes screening tests to at-risk beneficiaries
  - Significantly decrease the payment for drugs provided for cancer treatment, which could reduce reimbursement in this area by 9 percent

Medicare Reimbursement - Final Inpatient Ruling Federal Fiscal Year End September 2005

- Payment increase will average 6.2 percent for rural hospitals and 5.7 percent for urban hospitals
- Implements major payment and policy changes related to Medicare Prescription Drug, Improvement, and Modernization Act of 2003
- Lowers cost threshold for new technologies applying for add-on payments
- Decreases outlier amounts to $25,800 from originally proposed $35,035
- Updates labor market areas based on the revised definitions of Metropolitan Statistical Areas produced by the Office of Management and Budget using the 2000 Census data

Medicare Reimbursement - Ambulance Services Interim Final Ruling - Effective July 1, 2004

- Increase payments by $840 million nationally over next five years which is intended to ease the transition into a national fee schedule, which became effective April 1, 2002
- Urban services will see an increase of 1.0 percent to payments
- Rural services will see an increase of 2.0 percent to payments
- The rule also provides a 25 percent increase in mileage rates for miles in excess of 50 miles during an ambulance transport through 2008
- Certain areas with the lowest population's densities "super rural areas", the rule provides a 22.6 percent bonus increase through 2009

Reimbursement Update (Continued)

Medicare Outpatient Reimbursement - Final Rule Effective for Services January 1, 2004

- To increase 4.5 percent
- Outpatient outlier payments threshold set at 2.6 times the APC payment rate
- 2004 rates are based on costs taken from claims submitted by hospitals for outpatient services rendered in 2002
- Restructures new technology APC's to enable Medicare to pay more accurately for services assigned to these APC's

Physician Medicare Fee Schedules - Final Rule Effective for Services January 1, 2004

- Payment rates under Medicare physician fee schedule will DECREASE by 4.5 percent, however, actual Medicare spending for physician services will increase 1.7 percent
- Medicare is now expecting to pay $48.8 BILLION to 900,000 physicians and medical professionals in 2004 versus the $48.0 BILLION spent in 2003
- Final ruling includes several other changes in Medicare physician methodology, including:
    - Rebasing and revising the Medicare Economic Index (measure of physician inflation)...base year will now be 2000
    - Added adjustment for increased professional liability insurance costs
    - Added several new codes for the management and services provided to home dialysis patients

Medicare Prescription Drug and Modernization Act of 2003 Key Points for West Shore Medical Center

- For fiscal years 2005, 2006, and 2007, hospitals will receive inpatient payment increase equal to market basket if they participate in a Quality Improvement initiative with Medicare
- New Medical Technologies - By fiscal year 2005 the Act provides new additional funding for new technology
- Cost-Based Lab Payments - Hospitals with fewer than 50 beds, located in yet to be determined Qualified Rural Areas, defined as an area with a population density in the lowest quartile of all rural county populations, will receive cost based reimbursement for outpatient lab procedures for cost reporting periods July 1, 2004 through July 1, 2006
- Physician Incentive Bonus Payments - For services rendered January 1, 2005 through January 1, 2008, physicians will receive a 5 percent bonus payment for services rendered in pre-determined underserved counties
- Extended the Medicare outpatient "hold-harmless" provisions for small rural hospitals for two years to January 1, 2006

Reimbursement Update (Continued)

Other Medicare News

- **EMTALA Update** - In August 2003 CMS published rules clarifying the obligations of hospitals to patients requesting treatment for emergency medical conditions under the Emergency Medical Treatment and Active Labor Act (EMTALA)
- **Hospice 2004 Payment Update** - Average Medicare payments will increase overall by 0.6 percent, a full market basket increase as required by law, reduced for wage index changes, budget neutrality, and a wage index floor

Medicaid News

The Shulman Plan

House Appropriations Chairman Marc Shulman is looking at creating a five-year plan to decrease State spending on Medicaid from $2.2 billion to $1.45 billion by:

- Applying for federal government waiver (Medicaid 1115 Demonstration Waiver), which would allow the State to create a multi-tiered benefit structure which would increase the amount that Medicaid beneficiaries would be required to pay for medical services
- Requiring co-payments and deductibles from Medicaid beneficiaries based on income levels

Medicaid Spending - The cost of Medicaid for the year ended September 2003 increased by 12.6 percent and is estimated to increase 11.3 percent in 2004 and 10.8 percent in 2005

Office of Inspector General News

Physician Recruitment

- Reviewed OIG safe harbors on physician recruitment for Hospitals designated in a health professional shortage area (HPSA). Information on HPSA can be found at the following Web Site:bphc.hrsa.gov

- As reported in March 2003, OIG notes that deficiencies in nursing homes have increased since 1998. In 2001, 89 percent of all surveyed nursing homes received at least one deficiency, and the total average of deficiencies per nursing home increased from 5.1 in 1998 to 6.2 in 2001

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Office of Inspector General News (Continued)

OIG Offers Advice on Joint Ventures

OIG issued a special advisory bulletin warning health care providers that certain joint ventures arrangements could violate the anti-kickback statute. The specific arrangements relate to health care providers in one line of business that contract with providers of similar items or service, such as durable medical equipment or home oxygen supplies. For more go to http://oig.hhs.gov/winew.html

Highlights of OIG's 2004 Work Plan

The following items have been highlighted in OIG's 2004 Work Plan:

- Development of new, and modification of existing, safe harbor regulations under the anti-kickback statute
- Development of special fraud alerts, special advisory bulletins, and advisory opinions regarding the application of OIG sanction statutes
- Development and monitoring of Corporate Integrity Agreements (CIA) for providers that have settled their False Claims Act liability with the Federal Government
- Focus on home health services, Medicaid, and information system controls including compliance with HIPAA regulations
- Review of coding practices for Evaluation and Management (EM) Services, specifically the use of modifier 25, billing for consultations, and pricing for physician-prescribed drugs

Upcoming OIG Initiatives

- Issue guidance to Hospitals on effective corporate compliance plans
- Review medical necessity documentation, specifically invasive procedures
- Continued focus on upcoding and outlier payments
- Will target schemes proffered by consultants to increase revenue
- Work to reduce payment for outpatient surgery performed in a hospital setting to the same Medicare reimbursement paid at ambulatory surgery centers…could save Medicare $1.0 Billion

Other OIG News

- For YE 2002, the National Health Care Fraud and Abuse Control Program, established as part of HIPAA, reported that the government won or negotiated more than $1.8 BILLION in judgments, settlements, and administrative impositions in healthcare fraud cases and proceedings, a record since the program's inception. In addition, 361 criminal indictments were filed related to healthcare fraud and a total of 480 defendants were convicted for healthcare fraud-related crimes in 2002.

Tax Developments

IRS Initiative Targets Not-For-Profit Compensation Practices

Under the new Tax-Exempt Compensation Enforcement Project, the IRS will be requesting information from approximately 2,000 charities and foundations to review information and supporting documents on compensation practices and policies for specific executives. The IRS will also be reviewing insider transactions such as leasing arrangements to officers and others in the organization. More information can be reviewed at the following site: http://www.irs.gov/newsroom/article/0,,id=128328,00.html

IRS Joint Venture Unrelated Business Income Ruling

In a recent IRS Revenue Ruling (Revenue Ruling 2004-51), the IRS provided guidance for unrelated business income (UBI) for joint ventures between a not-for-profit 501(c)(3) organization and a for-profit organization. In short, joint ventures in which the tax exempt organization shares control with the for-profit organization can, under certain circumstances, be entered into without adverse exception and UBI implications.

Department of Labor - Regulations Issued for Overtime Eligibility for White-Collar Workers under the Fair Labor Standards Act Highlights

- Minimum salary level for overtime-exempt eligibility was increased to $455 per week from $155
- Revisions were made to executive, administrative, and professional exemptions to clarify the duties required for overtime eligibility
- "Highly Compensated" exemption is now available for those employees who earn at least $100,000 and customarily and regularly perform exempt duties

Fair Pay regulations are to take effect August 23, 2004. Information detailing a complete listing of all changes as well as an outline of training materials can be found at the Department of Labor Web Site

HIPAA Update

"HIPAA: it's not just the law....it's an adventure?"

The Continuing HIPAA Imperative

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) was passed by Congress to reform the insurance market and simplify healthcare administrative processes. The administrative simplification portion of HIPAA is aimed at reducing administrative costs and burdens in the industry by adopting and requiring the use of standardized electronic transmission of administrative and financial data. Currently, 26 cents of each healthcare dollar is spent on administrative overhead. The use of electronic data interchange (EDI) in a standard format between partners will allow transactions to occur in a more expedient and cost-effective manner. This Transaction and Code Sets segment of HIPAA spells out the rules governing these transactions.

HIPAA also addresses Security of the information that is transmitted. Standards have been developed for all health plans, clearinghouses, and providers ("covered entities") to follow regarding the transmission and storage of all health information to ensure integrity, availability, and confidentiality of the records in all phases of the transaction.

As well, Privacy standards have also been developed under the auspices of HIPAA. These standards explicitly define what are appropriate and inappropriate disclosures of protected health information (PHI). The HIPAA Privacy Standards are the new mandates industry-wide for the definition of privacy in healthcare.

Effective Dates

HIPAA Administrative Simplification Rules	Compliance Date*
Privacy	April 14, 2003
Transactions and Code Sets	October 16, 2003
National Employer Identifier	July 30, 2004
Security	April 21, 2005
National Provider Identifier	May 23, 2007
*Note: all compliance dates are extended by one year for small health plans with the exception of the compliance date for Transactions & Code Sets	

HIPAA Update (Continued)

HIPAA Enforcement Procedures

The interim final rule for the enforcement of HIPAA has been published. This rule deals with the enforcement of the Privacy regulations by the Office of Civil Rights (OCR) as well as the enforcement of the remainder of HIPAA by the Centers for Medicare and Medicaid (CMS). Both OCR and CMS intend to promote voluntary compliance through technical assistance and guidance with the rules. The enforcement process will be complaint-driven. Regarding the Privacy Rule, OCR will attempt to resolve matters by informal means before issuing findings of non-compliance. This process will consist of progressive steps that will provide opportunities to demonstrate compliance or submit a corrective action plan. A Civil Money Penalty (CMP) may be assessed by OCR to a covered entity should these compliance steps fail. For transactions, CMS will focus on obtaining voluntary compliance and use a complaint-driven approach for enforcement of HIPAA's electronic transactions and code sets provisions. When CMS receives a complaint about a covered entity, it will notify the entity in writing that a complaint has been filed. Following notification from CMS, the entity will have the opportunity to 1) demonstrate compliance, 2) document its good faith efforts to comply with the standards, and/or 3) submit a corrective action plan.

Transaction Contingency Planning Guidelines

CMS has recognized that, due to the complexity of implementing transactions, many organizations were not able to meet the October 16, 2003 compliance deadline. For those covered entities experiencing difficulties implementing transactions, a contingency plan is an alternate way of doing business when established routines are disrupted. In the case of the October 16, 2003 deadline, a contingency plan should address the potential interruption of claims processing and claims payment due to problems with transmission using the new HIPAA transaction standards. Just as each covered entity is different, there is no single contingency approach that would be appropriate for all covered entities and all situations. In addition, larger covered entities may need more than one contingency plan.

Final Security Rule

The security standards define administrative, physical, and technical safeguards to protect the confidentiality, integrity, and availability of electronic PHI. The scope of the final Security rule has been reduced and is now narrower than the Privacy rule. The final Security rule only covers electronic PHI, whereas the Privacy rule covers PHI in any form. Additionally, the proposed "Electronic Signature" standards, and all its subheadings were removed and will be issued as a separate future regulation.

The final Security rule aligned regulations more closely with the Privacy rule. Redundant implementation features, such as areas of access control, authorization, and training, were either removed or combined. Definitions of terms have been clarified, and various requirements were renamed. For example, Certification was renamed to Evaluation. The final rule is less prescriptive in its implementation specifications and therefore provides more flexibility but also requires more decision-making and documentation thereof on the part of the covered entities.

HIPAA Update (Continued)

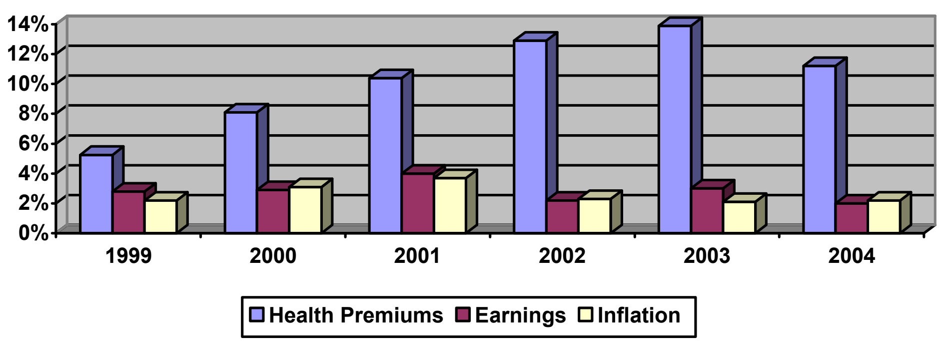
Disaster Recovery and Business Continuity Planning

Considered by many healthcare organizations as important but often lacking, disaster recovery and business continuity planning is a required element of the final Security rule. Imagine the consequences on your Organization if the information systems are inoperable due to fire, flood, terrorism, natural disaster, or cyber-related security incidents. Many covered entities have re-considered their preparedness to disruptions in information systems. Lack of timely recovery does not only disrupt services, but can also affect the ability to generate revenue, serve patients/residents/clients, and can potentially cause irrecoverable damage to reputation and competitive advantage. Best practices dictate management should review their current preparedness and update their disaster recovery and/or business continuity plans on a regular basis.

Other Healthcare News

5 Million Fewer Jobs Offer Health Insurance Benefits

According to a recently issued Kaiser Family Foundation and Health Research and Education Trust study, there are at least 5 million fewer jobs offering health insurance in 2004 than were in 2001. Some of the findings included a decrease in employers offering health insurance, from 68 percent in 2001 to 63 percent in 2004, the average annual premium for a family of four grew to $9,950, and if participating in a PPO, the most common type of plan, the premium hit $10,217, the first time over $10,000. In addition, over the past 6 years, health insurance premiums have grown at a much faster rate than earnings and inflation as detailed below:



Source: The Kaiser Family Foundation; Health Research and Educational Trust

Other Healthcare News (Continued)

Number of Uninsured Americans Continues to Increase

The Census Bureau reported in August 2004 that the number of Americans without health insurance continues to increase based on 2003 data. An additional 1.3 million individuals were without health insurance as compared to 2002, which now totals approximately 45 million people. Approximately 15.6 percent (15.2 percent in 2002) of the population are currently without health insurance. About 60.4 percent (61.3 percent in 2002) of the population are covered by employer offered health insurance and the number of individuals covered by government plans increased to 26.6 percent (25.7 percent in 2002).

Standards and Poor's 2004 Mid-Year Report

Has cautioned that many of the very favorable financial indicators over the past few years might be at their peak and many providers face a possible downward trend being driven by the following factors:

- Growing burden of bad debts and charity care with continued rising tide of uninsured and underinsured patients
- Federal deficits that call into question the federal governments long term ability to adequately fund the Medicare program
- Long-term questions regarding the maintenance of an adequate and more importantly affordable supply of nurses and physicians
- Reductions in Medicaid payments
- Emerging force of quality measurement and electronic health record
- Overall development of new technology (usually very costly) and pharmaceuticals

National Plan for Health Information Technology Released

In July 2004 the Department of Health & Human Services released its framework for a strategic action on the nation's health information technology infrastructure in a report called *The Decade of Health Information Technology: Delivering Consumer-Centric and Information-Rich Health Care*. Four goals are as follows:

1. Information Clinical Practice - Increase the reward for adopting electronic health records while lowering the cost

2. Interconnection Clinicians - Allow information to move with consumers from one point of care to another

3. Personalizing Care - Make information available to consumers

4. Improving Population Health - Improve both the public health and the quality of care delivered through best practice dissemination and use

Other Healthcare News (Continued)

House Committee Seeks Information on Cost-Shifting To Uninsured

In a July 2003 letter to 20 large health systems, the House Energy and Commerce Committee requested extensive information about billing practices related to the uninsured. The letter, from Committee Chairman Billy Tauzin (R-La.) and Oversight and Investigations Subcommittee Chairman James Greenwood (R-Pa.), stated this request was part of "an investigation into the billing practices of certain medical providers under which the uninsured are expected to pay substantially higher amounts for medical services than third-party health plans…or government health care programs." The health systems addressed comprise about 15 percent of the nation's acute care hospitals.

Healthcare Spending - The rise in healthcare spending per privately insured American decreased from 2002 to 2003, as noted in following table:

Category	Percent Increase in 2002	Percent Increase in 2003
Total Healthcare	9.5 percent	7.4 percent
Inpatient Care	8.4 percent	6.5 percent
Outpatient Care	12.9 percent	11.0 percent
Physicians Services	6.5 percent	5.1 percent
Prescription Drugs	13.2 percent	9.1 percent

Source: Center for Studying Health System Change (HSC)

Nursing Home Web Site Targets Quality - Site provides information on quality of care, state inspection results, complaints, and staffing. Site can be found at www.medicare.gov/nursing/overview.asp

Did You Know?

- Based on a report recently published by Hewitt Associates, initial data indicates that HMO premiums for 2005 will increase 13.7 percent as compared to 13.0 percent reported last year. In addition, companies continue to make significant changes to plan provisions including changes in required deductibles. Currently in 2004, 47 percent of companies have a $15 co-payment versus 24 percent of companies in 2002

- According to an AHA study issued in May 2004, Hospitals support one out of every nine jobs in the United States and directly provide $429 Billion to the economy, and over $1.3 Trillion when all indirect related benefits of hospitals are factored in

- According to the 2003 Annual Employer Health Benefits Survey released by the Kaiser Family Foundation and Health Research and Educational Trust, the typical family insurance policy now totals $9,068 or a 13.9 percent increase from 2002 (highest increase since 1990). On average employers are paying 73 percent and employees paying 27 percent of this cost (same as 2002)

Other Healthcare News (Continued)

Did You Know? (Continued)

- The number of physicians has increased by 26 percent from 1991 to 2001 according to a report issued by the General Accounting Office. We now have approximately 239 physicians for every 100,000 people in the United States compared to 214 from the previous 10-year period

- By the year 2050, between 5.7 and 6.5 million long-term care workers will be needed to meet the demands of 27 million baby boomers, reports HHS Secretary and Department of Labor Secretary. See report at www.aspe.hhs.gov/daltcp/reports/ltcwork.pdf

Report for Addressing Health Care Worker Shortage - A report commissioned by the Milbank Memorial Fund addresses various policies addressing the growing shortage of health care workers. Report can be found at http://www.milbank.org

Charitable Giving - A significant decrease in charitable giving was reported by the Association of Healthcare Philanthropy's 2002 Annual "Report on Giving" as detailed below:

Year	Total Charitable Giving
2002	$5.53 Billion
2001	$8.01 Billion

Required Communication to the Board of Trustees

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To the Board of Trustees
West Shore Medical Center

We have recently completed our audit of the financial statements of West Shore Medical Center for the year ended June 30, 2004. As required by auditing standards generally accepted in the United States of America, the independent auditor is required to make several communications to the "Audit Committee" or a governing body having oversight responsibility for the audit. The purpose of this communication is to provide you with additional information regarding the scope and results of our audit that may assist you with your oversight responsibilities of the financial reporting process for which management is responsible. This report is intended solely for the use of the Board of Trustees and others within the Organization.

Auditor's Responsibility Under Auditing Standards Generally Accepted in the United States of America

We conducted our audit of the financial statements of West Shore Medical Center in accordance with auditing standards generally accepted in the United States of America. The following paragraphs explain our responsibilities under those standards:

Management has the responsibility for adopting sound accounting policies, for maintaining an adequate and effective system of accounts, for the safeguarding of assets, and for devising an internal control structure that will, among other things, help ensure the proper recording of transactions. The transactions that should be reflected in the accounts and in the financial statements are matters within the direct knowledge and control of management. Our knowledge of such transactions is limited to that acquired through our audit. Accordingly, the fairness of representations made through the financial statements is an implicit and integral part of management's responsibility. We may make suggestions as to the form or content of the financial statements or even draft them in whole or in part, based on management's accounts and records. However, our responsibility for the financial statements is confined to the expression of an opinion on them. The financial statements remain the representations of management.

The concept of materiality is inherent in the work of an independent auditor. An auditor places greater emphasis on those items that have, on a relative basis, more importance to the financial statements and greater possibilities of material error than with those items of lesser importance or those in which the possibility of material error is remote.

For this purpose, materiality has been defined as "the magnitude of an omission or misstatement of accounting information that, in light of surrounding circumstances, makes it probable that the judgment of a reasonable person relying on the information would have been changed or influenced by the omission or misstatement."

To the Board of Trustees
West Shore Medical Center

Auditor's Responsibility Under Auditing Standards Generally Accepted in the United States of America (Continued)

An independent auditor's objective in an audit is to obtain sufficient competent, evidential matter to provide a reasonable basis for forming an opinion on the financial statements. In doing so, the auditor must work within economic limits; the opinion, to be economically useful, must be formed within a reasonable length of time and at reasonable cost. That is why an auditor's work is based on selected tests rather than an attempt to verify all transactions. Since evidence is examined on a test basis only, an audit provides only reasonable assurance, rather than absolute assurance, that financial statements are free of material misstatement. Thus, there is a risk that audited financial statements may contain undiscovered material errors or irregularities. The existence of that risk is implicit in the phrase in the audit report, "in our opinion."

Significant Accounting Policies

Auditing standards call for us to inform you regarding the initial selection of, and changes in, significant accounting policies or their application. In addition, we are expected to inform you about the methods used to account for significant unusual transactions and the effect of significant accounting policies in controversial or emerging areas for which there is a lack of authoritative guidance or consensus. The significant accounting policies are described in Note 1 to the financial statements. There were no significant unusual transactions or controversial or significant emerging areas for which new accounting policies were needed.

Management Judgments and Accounting Estimates

Auditing standards call for us to report to you on accounting estimates that are particularly sensitive because of their significance to the financial statements or because of the possibility that future events affecting them may differ markedly from management's current judgments. Further, we are expected to report to you covering the process used by management in formulating particularly sensitive accounting estimates and about the basis for our conclusions regarding the reasonableness of those estimates. In this connection, we are reporting the following matters:

To the Board of Trustees
West Shore Medical Center

Management Judgments and Accounting Estimates (Continued)

As described in the notes to the financial statements, a significant portion of the Center's net patient revenue is received from Medicare, Medicaid, Blue Cross Blue Shield of Michigan, and various HMO programs. These programs pay the Center less than full charges for the services rendered to patients. Management has estimated the amount of loss resulting from these program's payment methods based on cost report models for the year and other anticipated disallowances and adjustments. Our conclusions regarding the reasonableness of those estimates are based on reviewing the cost report model and related documents, historical information related to these accounts, and settlements with these third parties during and after the end of the year.

Management has also estimated bad debt expense for the year, as well as the related allowance for uncollectible accounts. These estimates are based on percentage of patient revenue and review of accounts receivable aging categories. The percentages used are based on prior experience. Our conclusions regarding the reasonableness of these estimates are based on reviewing historical trends, on testing collectibility of large accounts, and on testing management's computations.

Management has also estimated the ultimate expense, including litigation and settlement expense, for incidents, which may result in malpractice claims occurring during the year, as well as the estimate of those claims, which have not been reported at year end. This estimate is based on conclusion reached by in-house risk manager, legal counsel, discussions with the Center's insurance carrier, and on historical outcomes of previous cases in the Center's geographic area. Our conclusions regarding the reasonableness of this estimate are based on discussions with management, the risk manager, confirmation of outstanding and open cases with the insurance carrier, and communication with outside counsel.

Significant Audit Adjustments

Auditing standards call for us to report to you significant audit adjustments that, in our judgment, may not have been detected except through the auditing procedures we performed. There were no significant audit adjustments made during the June 30, 2004 audit of the financial statements of West Shore Medical Center.

To the Board of Trustees
West Shore Medical Center

Disagreements With Management

In the process of conducting an audit, various matters will be discussed with management. In that process, significant differences of opinion may arise regarding the scope of the audit, disclosures to be included in the financial statements, or the wording of our report. In the interest of keeping you informed of all significant matters, such differences are required to be reported to you even though they are satisfactorily resolved. There were no disagreements with management over the application of accounting principles or the basis for management's judgments about accounting estimates. Additionally, there were no disagreements regarding the scope of the audit, disclosures to be included in the financial statements, or the wording of the auditor's report.

Consultation With Other Accountants

When management consults with other accountants about significant accounting and auditing matters, auditing standards require that we present our views on those matters to you. To our knowledge, there were no such consultations with other accountants.

We welcome any questions you may have regarding the foregoing comments, and we would be happy to discuss any of these or other questions that you might have at your convenience.

Plante & Moran, PLLC

September 16, 2004